

STANDARD CERTIFICATE OF DEATH

45566

STATE FILE NUMBER

FILED DEC 30 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

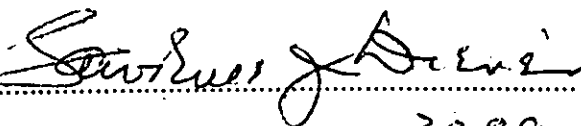
12025

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN University City	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 37 Hamilton Med. Center		d. STREET ADDRESS 1029 Irma	
Length of stay in lb 5 yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DORA Middle ARNOSKE Last		4. DATE OF DEATH Dec. 14, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk.
9. AGE (In years last birthday) ab. 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11a. FATHER'S NAME Unk		11b. MOTHER'S MAIDEN NAME Unk.	
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. None	
13. NAME OF HUSBAND OR WIFE Abraham		14. CITIZEN OF WHAT COUNTRY? USA	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident		INTERVAL BETWEEN ONSET AND DEATH 40 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebro arterio sclerosis		years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331x	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Death occurred at 9:30 AM		to Dec 14, 1957 and last saw her alive on Dec 14, 1957 m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Claron Hendin MD		22b. ADDRESS 607 No Grand	
22c. DATE SIGNED 12/14/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 12/15/57	
23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol		23d. LOCATION (City, town, or county) Ladue, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 Mc Person		25. DATE RECD. BY LOCAL REG. DEC 16 '57	
26. REGISTRAR'S SIGNATURE Carl Smith mo mkb			

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 3988

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.